Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: New Jersey Department of of Human Resources
Docket No. A-05-120
Decision No. 2107

DATE: August 20, 2007

DECISION

The New Jersey Department of Human Services (New Jersey) appealed a decision by the Centers for Medicare & Medicaid Services (CMS) to disallow approximately $11.1 million in federal Medicaid reimbursement for expenditures by the New Jersey Department of Corrections (NJDC) between July 1, 1997 and June 30, 2001. Those expenditures were characterized by New Jersey as Medicaid "disproportionate share hospital" (DSH) payments for hospital services, but in fact the expenditures reflected the costs of services furnished by the hospital to state prison inmates. We affirm the disallowance because we conclude that New Jersey's Medicaid State plan expressly barred New Jersey from treating NJDC's expenditures as DSH payments.

Legal Background

Medicaid, established under title XIX of the Social Security Act (Act),[1] is a program in which the federal government and states jointly finance the provision of medical care to financially needy and disabled persons. Act §§ 1901, 1903. Each state administers its own Medicaid program subject to broad federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by the Secretary of Health and Human Services (Secretary). Id. § 1902; 42 C.F.R. § 430.0. Once its plan is approved, a state becomes entitled to receive federal reimbursement, called federal financial participation (FFP), for a percentage of its program-related expenditures. Act § 1903(a). Those expenditures include payments to hospitals, physicians, and other providers for the medical services they

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

furnish to Medicaid recipients. Section 1905(a)(28)(A) of the Act specifically excludes from medical assistance any payments for "care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."

Section 1903(a)(1) of the Act directs the Secretary to reimburse a state for the amount that it expends "as medical assistance under the State plan" (emphasis added). The term "medical assistance" means payment for various categories of medical services, including "hospital services." Act § 1905(a). Thus, section 1903(a)(1) makes reimbursable only those medical expenditures made by a state in accordance with the approved state plan. Perales v. Sullivan, 948 F.2d 1348, 1355 (2nd Cir. 1991); Colorado Dept. of Health Care and Policy Financing, DAB No. 2057 (2006); New Jersey Dept. of Human Services, DAB No. 1652 (1998).

A state pays for hospital services based on payment rates that are determined in accordance with the state plan. Act § 1902(a)(13); 42 C.F.R. §§ 447.252(b), 447.253(i). In setting hospital payment rates, a state Medicaid program must take account of hospitals that serve "a disproportionate number of low income patients with special needs." Act § 1902(a)(13)(A)(iv). In order to comply with that mandate, a state must include in its state plan provisions for making "payment adjustments," also known as DSH payments, to hospitals that meet the definition of a disproportionate share hospital. Act § 1923. A DSH payment supplements what the Medicaid program ordinarily pays the hospital (based on the program's standard rates) for inpatient hospital services furnished to Medicaid recipients. Act § 1923(a)(1)(B).

Section 1923(g)(1)(A) of the Act provides that DSH payments to a hospital in a given year may not exceed the hospital's uncompensated costs – that is, costs not reimbursed by the patient, Medicaid (based on standard payment rates), or other source of "third party coverage" – of furnishing hospital services to "individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage)[.]"[2] Section 1923(g)(1)(A)

[2] We do not in this case address any question of whether Medicaid payments can ever properly be made for hospital services rendered to inmates who are shown to be Medicaid-eligible. In any case, any Medicaid payments made to a hospital on behalf of Medicaid-eligible inmates would be removed from the uncompensated

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further provides that state agency payments to a hospital for hospital services provided to indigent patients will not be considered a source of third party payment. The Board and the courts have held that state agency payments on behalf of inmates do not constitute payments on behalf of indigents and that inmates per se are not uninsured because they have a source of third party coverage in the state's obligation to pay for their needs. New York State Dept. of Health, DAB No. 2037 (2006); St. Francis Medical Center v. Shalala, No. CIV. A. 97-33212GEB, 1998 WL 230233 (D. N.J. May 5, 1988) (unpublished).

On August 16, 2002, CMS issued State Medicaid Director Letter (SMDL) #02-013. NJ Ex. C. The following section of the letter explains CMS's policy on the inclusion of the costs of hospital services provided to inmates and paid for by the state as uncompensated care costs in the calculation of a hospital's DSH payment adjustment limit:

> **Prisoner Inmate Care and the Calculation of the OBRA 93 Uncompensated Care Cost Limits**
> Section 1923(g) of the Social Security Act establishes a hospital-specific DSH limit. It limits Medicaid payments to the costs incurred during the year of furnishing hospital services by the hospital to individuals who are either eligible for medical assistance under the State plan or have no health insurance or source of third party coverage for services provided during the year. Inmates of correctional facilities are wards of the State. As such, the State is obligated to cover their basic economic needs (food, housing, and medical care) because failure to do so would be in violation of the eighth amendment of the Constitution. Therefore, because these individuals have a source of third party coverage, they are not uninsured, and the State cannot make DSH payments to cover the costs of their care.

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[2](...continued)
care calculations as well, due to a provision specifically requiring the adjustment to be "net of [Medicaid] payments." Act § 1923(g)(1)(A). Moreover, New Jersey does not argue that it had determined any of the inmates whose costs of care are at issue here to be Medicaid-eligible or that it made any Medicaid payments on their behalf. Nor did New Jersey argue that its State plan would allow it to include in its DSH calculation any payments for prisoner hospital care based on such eligibility.

NJ Ex. C.[3]

Case Background

On June 6, 2001 – prior to the issuance of SMDL #02-013 – CMS approved New Jersey State plan amendment (SPA) 97-14, which states:

> Disproportionate Share Hospital (DSH) payments to acute care hospitals shall include payments by any agency of the State of New Jersey for health care services provided to Medicaid beneficiaries and uninsured individuals. These [DSH] payments shall be made to each hospital at the amount of the payment by the State agency for Medicaid and uninsured individuals not to exceed 100 percent of the costs incurred by the hospital during the year serving Medicaid beneficiaries and uninsured individuals less Medicaid payments including any other DSH payment methodology and payments from or on behalf of uninsured patients. The DSH payments shall replace the portion of total State agency payments to each hospital supporting services to Medicaid beneficiaries and uninsured patients. These payments from other agencies do not represent payments for prisoner inmate care.

CMS Ex. F (emphasis added). SPA 97-14 had an effective date of April 1, 1997. Id.

The final sentence of SPA 97-14 was added at CMS's insistence. Christine Hinds, a CMS Health Insurance Specialist who participated in the amendment approval process, stated in a declaration that the purpose of the amendment's final sentence was "to ensure that New Jersey would not claim monies spent on prisoner inmate care as DSH expenditures for purposes of collecting FFP." CMS Ex. B ¶ 5. Hinds also stated that she "conveyed CMS' interpretation of the additional required text" to Deborah Bradley, New Jersey's Acting Medicaid Director, and that

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[3] SMDL #02-013 further indicates that permitting a state to treat the costs of hospital services furnished to prison inmates as uncompensated costs for purposes of determining a hospital's DSH payment limit would create the potential for a state to evade other statutory or regulatory provisions – such as section 1905(a) of the Act and 42 C.F.R. §§ 435.1009-10 – that place limits on FFP for Medicaid payments for services provided to inmates of public institutions. NJ Ex. C.

Bradley "understood the reason why CMS was requiring that the text be added." Id. ¶ 6. New Jersey signaled its acceptance of the additional text in a May 23, 2001 letter from Bradley to the CMS Associate Regional Commissioner. CMS Ex. C. (New Jersey offered no evidence rebutting the declaration of Ms. Hinds.)

In 2004, the Department of Health and Human Services Office of Inspector General (OIG) issued a report of an audit that examined New Jersey's Medicaid FFP claims for the period July 1, 1997 through June 30, 2001. NJ Ex. B. The OIG found that, for this four-year period, New Jersey had received $11,114,820 in FFP for payments made by the NJDC to St. Francis Medical Center (St. Francis) for hospital services furnished to state prison inmates.[4] Id. (pg. 28 of Report). The OIG also found that New Jersey had claimed FFP for NJDC's hospital payments by classifying them as DSH payments. Id. (pg. 27 of Report). Based on these findings and on SPA 97-14, the OIG concluded that the FFP claims for NJDC's hospital payments were inconsistent with the state plan and unallowable for that reason. Id. (pg. 28 of Report).

In a letter responding to the audit findings, New Jersey did not deny that the expenditures for which it claimed $11,114,820 in FFP represented DSH adjustments for hospital services provided to prison inmates at St. Francis. Instead, New Jersey asserted that any statutory or regulatory restrictions on Medicaid payment for services to prison inmates should not apply to the expenditures because they were DSH adjustments rather than direct payments for services to the inmates. New Jersey argued that because the DSH adjustments affected only the rates of payment for services to Medicaid recipients, and because those rates were ultimately used to make FFP claims for expenditures made on behalf of Medicaid recipients, the DSH adjustments were allowable under federal law and the terms of its state plan. NJ Ex. B (May 1, 2003 letter from Gwendolyn L. Harris (New Jersey) to Timothy J. Horgan (OIG)).

CMS concurred with the OIG's audit findings, stating that "because the costs claimed here were not claimed in accordance with the State plan, such costs do not qualify as medical assistance and constitute an overpayment under section 1903(d)(2)

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[4] The OIG found that St. Francis "was under contract with the State to provide services because it had a secure section for inmates who were admitted as inpatients." NJ Ex. B (report pg. 28). "Once these inmates received [hospital] care, they were returned to prison." Id.

of the Social Security Act." NJ Ex. A. Accordingly, CMS disallowed $11,114,820 in FFP for "prison inmates' inpatient and outpatient health care costs claimed by New Jersey as acute care disproportionate share hospital (DSH) expenditures incurred from July 1, 1997 through June 30, 2001." Id.

New Jersey now insists that the FFP claims disallowed by CMS were in fact allowable under its state plan. NJ Br. at 1.

Discussion

The essential facts of this case are not in dispute. NJDC made payments to St. Francis for costs of medical care that St. Francis furnished to state prisoners under contract with New Jersey. New Jersey characterized its payments as DSH adjustments, for which it obtained approximately $11.1 million in federal Medicaid reimbursement.

There is also no dispute that SPA 97-14 is applicable to the disallowed FFP claims. Although CMS did not approve SPA 97-14 until June 2001, the amendment's effective date was April 1, 1997, meaning that it applied to state expenditures made on or after that date.[5] The FFP claims at issue here relate to expenditures made on or after July 1, 1997.

Thus, the key issue we must resolve is whether the state plan — in particular, SPA 97-14 — permitted New Jersey to treat NJDC's payments to St. Francis as Medicaid DSH payments for purposes of obtaining FFP. In resolving disputes about the state plan's meaning, we look first at its text. South Dakota Dept. of Social Services, DAB No. 934 (1988). If the text's meaning is plain, we apply the text according to its plain meaning. Id. When the text is ambiguous or its meaning uncertain, we will consider contemporaneous documentary evidence of intent. Id. We generally defer to the state's interpretation of the plan's language if that interpretation is reasonable, "gives effect to the language of the plan as a whole, and is supported by evidence of consistent administrative practice." Colorado Dept. of Health Care and Policy Financing, DAB No. 2057, at 10 (2007). The Board will also consider whether the putative interpretation is an official one by the state or merely "an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." South Dakota at 4. Furthermore, the state's interpretation

[5] The regulations allow the effective date of a state plan amendment to be any date requested by the state if CMS approves it. 42 C.F.R. § 430.20(b)(3).

"cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements." Id.

Although SPA 97-14 appears awkwardly written, its meaning can be discerned from its text. The amendment provides, in the first sentence, that New Jersey's DSH payments shall include payments by any state agency to an acute hospital for hospital services furnished to Medicaid beneficiaries and uninsured persons. CMS Ex. F. The amendment further provides, in the next-to-last sentence, that DSH payments shall "replace" the "State agency payments . . . supporting services to Medicaid beneficiaries and uninsured patients." Id. According to New Jersey, this means that state agency payments supporting Medicaid beneficiaries and uninsured patients will be "process[ed] . . . through the State's Medicaid system" as DSH payments. NJ Br. at 13-14.

The amendment's final sentence states that "payments from other agencies do not represent payments for prisoner inmate care." CMS Ex. F (emphasis added). Given its context, the term "payments from other agencies" can refer to only one of two things: (1) the "State agency payments . . . supporting services to Medicaid beneficiaries and uninsured patients" that the preceding sentence indicates will be "replaced" by DSH payments; or (2) the DSH payments themselves.

Whatever meaning is intended, the final sentence indicates that the "payments" in question "do not represent payments for prisoner inmate care." Because the final sentence attempts to characterize "payments from other agencies," the only reasonable meaning of the words "do not represent" is "does not mean or describe" or "are not equivalent to." See, e.g., Webster's Third New World Dictionary (1976) (defining "represent" to mean, among other things, portray, delineate, "present by description," or "describe as having a specified character or quality"). New Jersey has suggested no reasonable alternative meaning for these words.

Thus, if "payments from other agencies" are the "State agency payments" mentioned in the immediately preceding sentence, then the final sentence must mean: "State agency payments supporting services to Medicaid beneficiaries and uninsured patients" do not mean ("do not represent") payments for prison inmate care. The final sentence must, of course, be read together with the immediately preceding sentence, which provides that state agency payments to Medicaid beneficiaries and uninsured patients will be replaced by DSH payments. When the last two sentences of SPA 97-14 are read together, they provide that state agency payments "replaced" with DSH payment adjustments do not mean any state

agency payments to DSH hospitals for the medical care of prison inmates.

New Jersey has offered two mutually inconsistent interpretations of SPA 97-14. First, in a May 2003 response to the OIG audit, New Jersey stated that it "intended [the amendment's final sentence] to preclude claiming for any costs of medical facilities operating within a correctional facility." NJ Ex. B. (May 1, 2003 letter, at 3)). New Jersey does not advance that interpretation in this appeal, and we find nothing in the text of SPA 97-14 to support it in any event. There is simply nothing in SPA 97-14 that could reasonably be interpreted as referring to "costs of medical facilities operating within a correctional facility." The entire amendment deals only with payment adjustments for services provided at DSH hospitals.

Second, New Jersey contends (in this appeal) that SPA 97-14's final sentence actually authorizes the replacement of prison inmate expenditures with DSH payments. New Jersey asserts that DSH payments are not payments for specific services but payment rate adjustments that are meant to "'assist facilities that have high levels of uncompensated care.'"[6] Reply Br. at 1-2 (quoting

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[6] CMS agrees with the premise that DSH payments are not supposed to constitute payments for specific services, but argues that New Jersey has essentially tried to use its DSH payment process to obtain FFP for expenditures made for specific services furnished to specific prison inmates. In a December 2000 Federal Register notice announcing an administrative hearing to reconsider the disapproval of a Rhode Island state plan amendment, CMS provided an explanation that persuasively supports its position here:

> Section 1923 of the Act establishes Federal requirements for DSH payments to qualifying hospitals. DSH payments may be reasonably related to the costs, volume or proportion of services provided to patients eligible for medical assistance under a State plan or to low-income patients. Unlike other Medicaid payments, DSH payments are not payments for specific services, but are made to recognize that DSH facilities "serve a disproportionate share of low income patients with special needs." The payments described in this [Rhode Island] State plan are payments for specific services to specified inmates . . . rather than payments available for the overall costs of serving a

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65 Fed. Reg. 81,877, 81,878). Relying on that unobjectionable proposition, New Jersey then asserts that the DSH payments that "replaced" NJDC's payments to St. Francis should not be regarded as payments for specific services such as hospital care for prison inmates. Id. at 2-3. New Jersey further asserts that —

> [it] added the [final] sentence [of SPA 97-14] without protest because it did not conflict with the State's understanding of the state Plan Amendment. In fact, New Jersey agreed that the reclassified payments do not represent payments for prisoner care because they are DSH payments under the SPA.
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> The State read the sentence in the context of the SPA as a whole . . . . Thus, once the State agency payments are replaced by DSH payments, they no longer [represent] payments for specific individuals or services. Accordingly, the claims at issue are consistent with federal law and the State Plan Amendment approved by CMS.

Id. at 2. New Jersey seems to be saying here that, when SPA 97-14 was approved in June 2001, it interpreted the amendment's final sentence as merely *confirming* that state agency payments to a hospital for prison inmate care would not be regarded (for Medicaid program purposes) as having any connection with hospital services for prisoners once those payments were "replaced" — or processed — by the Medicaid program as DSH payments.

This interpretation is not reasonable. It is not supported by the amendment's text, which New Jersey virtually ignores or misconstrues.[7] New Jersey's interpretation basically rewrites the

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> disproportionate share of low-income patients. It is important to note that, while States may use DSH payments generally to assist facilities that have high levels of uncompensated care, the DSH provisions do not authorize payments for specific services to non-Medicaid eligible individuals.

65 Fed. Reg. 81,877, 81,878 (December 27, 2000).

[7] New Jersey says: "Given that DSH payments are not
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text to say that "payments from other agencies include payments for prisoner inmate care." New Jersey's most recent interpretation also ignores the evidence of CMS's purpose in requiring New Jersey to add the amendment's final sentence. As the unchallenged declaration of Christine Hinds indicates, that purpose was "to ensure that New Jersey would not claim monies spent on prisoner inmate care as DSH expenditures for purposes of collecting FFP." CMS Ex. B ¶ 5. There is ample evidence that New Jersey was aware of that purpose when SPA 97-14 was approved in June 2001.[8]

Even if New Jersey's interpretation could be considered reasonable (which it cannot), the record undermines any claim that New Jersey actually relied on that interpretation in claiming FFP for NJDC's expenditures on prison inmate care. It appears that, prior to 1997, New Jersey did not regard or claim expenditures for prison inmate care as DSH payments under its then-existing State plan. Only in mid-1997, after retaining a consulting firm on a contingent fee basis to uncover additional reimbursable expenditures, did New Jersey begin claiming hospital expenditures for prison inmate care as DSH payments.[9] See NJ Ex. B (pg. 1, 3 of report)). At minimum, these additional claims reflected a material change in the state's method under the State

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payments for specific services, once the DOC [Department of Corrections] payments are replaced by DSH payments, they no longer 'represent' payments for specific services." Reply Br. at 3 (emphasis added). New Jersey misconstrues how the word "represent" is used in SPA 97-14. The word is not used to indicate that DSH payments will not be regarded as payments for specific services. Rather, the word is used to characterize the "payments from other agencies" that will, according to the amendment, be "replaced" with DSH payments.

[8] There is no evidence that, after CMS proposed additional language for SPA 97-14, New Jersey sought clarification of the amendment's meaning or in any way informed CMS that it intended to interpret the amendment in a manner consistent with the arguments it now presents.

[9] According to the OIG report, whose factual findings New Jersey does not dispute, the purpose of New Jersey's arrangement with the consultant was "to generate increased Federal reimbursement by identifying and submitting State expenses not previously claimed for Federal reimbursement." NJ Ex. B (pg. 22 of report).

plan for calculating DSH payments, a change that required prior CMS approval. See 42 C.F.R. § 430.12(c)(2) (requiring that the state plan provide that it will be amended when necessary to reflect, among other things, "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program"). New Jersey did submit a proposed amendment in 2001 by proposing SPA 97-14 and asking that it be effective back to 1997. By making claims based on the new methodology prior to CMS's approval of SPA 97-14, New Jersey knew that it risked disallowance of those claims if CMS disapproved the new methodology in whole or part. CMS made clear, however, that the proposed amendment would not be approved without language excluding expenditures for prison inmate care from its DSH payments. CMS Ex. B ¶¶ 4-5. Given that an apparent purpose of SPA 97-14 was to retroactively validate a change (dating to 1997) in New Jersey's DSH adjustment calculations regarding state agency payments for prison inmate care, we believe that it is disingenuous for New Jersey to suggest, as it did in its response to the audit, and as it does now in this appeal, that it had some interpretation of SPA 97-14 at odds with what it knew was CMS's purpose in insisting on the revision of that amendment.

We thus conclude that the only reasonable interpretation proffered for SPA 97-14 in these circumstances is that payments by any state agencies to a DSH hospital for the care of any prison inmates will not be replaced by DSH payments. New Jersey's FFP claims for the period July 1, 1997 to June 30, 2001 failed to adhere to that limitation, in that NJDC's hospital payments for prison inmate care were treated as DSH payments. Thus, the FFP claims for those payments were not in accordance with the state plan and were properly disallowed for that reason. Colorado Dept. of Health Care and Policy Financing at 1-2 (2006) ("To receive FFP, a state must claim the costs of medical assistance in accordance with its approved State plan"); New Jersey Dept. of Human Resources, DAB No. 115, at 1 (1980) (noting that the state plan provides the basis for claiming FFP).

New Jersey argues that CMS, in issuing the disallowance, "exceeded its statutory authority" by "basing the disallowance on the source of the DSH payment." Reply Br. at 4. New Jersey asserts that "nothing in the plain language of the Medicaid Act prohibits the inclusion of the cost of hospital services provided to prison inmates in the State's DSH calculation," and that although Congress required states to make DSH payments, "there is nothing in the Act which indicates how States should provide DSH payments to qualified hospitals or where the funds to make the required DSH payments may be obtained." Id.

In a related vein, New Jersey suggests that CMS's actions rest on a misinterpretation or misapplication of section 1923(g) of the Act:

> If, as CMS asserts [in SMDL #02-013], prisoners are neither uninsured nor indigent, then the cost of treating prisoners should not be included in establishing the hospital-specific DSH adjustment limit. The hospital-specific limit [in section 1923(g)] . . . did not, however, change the nature of DSH payments. DSH payments to qualified hospitals are not payments for specific services, they are adjustments to Medicaid rates. As such, DSH payments, like the ones made to St. Francis, are not payments for specific services, but adjustments to the hospitals' Medicaid rates. By attempting to exclude the payments to St. Francis from the State's DSH claim, CMS exceeded its authority by placing limits on how a State can make the DSH payments, and where the State can obtain the funds to make the DSH payments required by Congress.

Reply Br. at 5.

The argument that CMS overstepped its authority overlooks the fact that DSH payments are intended for a specific purpose — namely, to take account of a hospital's uncompensated costs of caring for Medicaid-eligible and low-income uninsured patients. See Act §§ 1923(a) (g)(1)(A). Prison inmates are not categorically included in these two groups, as we recognized in New York State Dept. of Health, DAB No. 2037 (2006). New Jersey, of course, has some flexibility to define in its state plan how it will calculate and make its DSH payments. Cf. Act § 1923(c) (allowing states to choose one of three methods for calculating the DSH "payment adjustment"). In SPA 97-14, New Jersey proposed a DSH payment methodology that would, in effect, use payments by any state agency for uncompensated care as the measure of DSH payment adjustments (which would in turn replace prior state payments from state-only sources). That proposal was unacceptable to CMS insofar as it failed to ensure that the state payments were indeed based on payments for the kind of uncompensated care for which DSH payments are permitted.

Contrary to New Jersey's suggestion, neither SPA 97-14 nor SMDL #02-013 imposes restrictions on where or how the state obtains the funds it uses to make DSH payment adjustments. These documents merely provide that costs of hospital services furnished to prison inmates for whom the state is responsible may not be included in the calculation of the DSH adjustments. The

House Report on the bill adding hospital-specific limits on DSH payments made clear that Congress was concerned with precisely the sort of transactions involved here, whereby a state seeks to obtain FFP in non-Medicaid costs that are the responsibility of the state. Thus, the report explained:

> The Medicaid program is intended to assist States in paying for covered acute and long-term care services for the poor. In the view of the Committee, use of Federal Medicaid funds for unrelated purposes, such as building roads, operating correctional facilities, balancing State budgets, is a clear abuse of the program.

H.R. Rep. 103-111, at 211-12 (1993), as reprinted in 1993 U.S.S.C.A.N. 378, 578-79 (emphasis added). Thus, CMS's view is entirely consistent with the statutory purpose of DSH payments. DSH payments based on hospital services furnished to prison inmates do not serve that statutory purpose when prison inmates' care is compensated by the State as part of its obligations. It was for that reason that CMS required, and New Jersey accepted, the language excluding payments representing prisoner care from DSH adjustment calculations. The problem, thus, was not that NJDC was the source of the payments but that the costs of the inmate care were not uncompensated costs incurred by a DSH hospital for which an adjustment to hospital payments was permissible.

In light of this discussion, New Jersey's contention that CMS exceeded its authority amounts to a request that we disregard the language that CMS wrote into SPA 97-14. We find no reason to do so. We have "consistently held that states are bound by the provisions of their approved state plans in the operation of a Medicaid program under Title XIX." Florida Dept. of Health and Rehabilitative Services, DAB No. 1100, at 10 (1989). We conclude that CMS did not violate the Medicaid statute in issuing the disallowance or requiring New Jersey to modify SPA 97-14.[10] As

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[10] Moreover, to the extent that New Jersey is contending that CMS exceeded its authority in demanding that SPA 97-14 prohibit DSH adjustments for prison inmate care, New Jersey could — and arguably should — have raised that objection earlier. If New Jersey believed that the additional language failed to conform with federal law, as it now apparently contends, it could have objected to the language when proposed, obtained a CMS determination disapproving SPA 97-14, and requested

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discussed, the applicable state plan language has a clear and limited purpose and effect, i.e., to bar New Jersey from treating its expenditures for prison inmate hospital care as DSH payments. In New York State Dept. of Health, DAB No. 2037, the Board determined that --

> permitting states to claim DSH payments for hospital services provided to all inmates would be to undermine the statutory restriction on federal payments even for those inmates who are Medicaid recipients. FFP is prohibited in medical services for inmates except for services that they receive as "patients in medical institutions," which CMS has long interpreted to mean inpatient services. In effect, the State's approach would allow it to use federal funds to pay for services received by non-Medicaid eligible inmates and for services received by Medicaid-eligible inmates for outpatient services. CMS's interpretation reconciles the inmate services and eligibility provisions with the DSH provisions. We find persuasive an interpretation that reads all parts of the Act in a manner consistent with each other and with the purposes of the Act. On the other hand, the State's interpretation unreasonably reads one part of the Act in a way that undermines another provision of the same Act.

New York at 12 (citations omitted).[11] The concerns that the Board

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administrative review of the determination by the Administrator of CMS pursuant to 42 C.F.R. § 430.18. Under that administrative review process, a state is entitled to an evidentiary hearing on whether state plan material is in compliance with federal requirements. 42 C.F.R. §§ 430.18(a), 430.60(a).

[11] We note that, in New York as here, the State made no attempt to demonstrate that any of the inmates involved were Medicaid-eligible or were Medicaid recipients who might be covered for inpatient services, depending on the interpretation of section 1905(a) of the Act and other legal requirements. We therefore have not in either case determined whether such eligibility might exist. Both states made payments from state funds based on the prisoners' status as inmates in state custody rather than claiming FFP in Medicaid payments made for their care. The point made in this excerpt is that allowing a state to treat all its payments for all inmates as "uncompensated care" provided by a DSH hospital would avoid the requirement for any
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expressed in New York also apply to the situation here, particularly given that the OIG determined that the costs on which the DSH payments were based actually included outpatient services to inmates (which CMS characterized as an independent basis for at least part of the disallowance). New Jersey Ex. B at 28; CMS Br. at 14 n.3 (citing § 1923(g)).

New Jersey also contends that the disallowance was based on an improper retrospective application of SMDL #02-013, which was issued after the period to which the disallowed FFP claims relate. Reply Br. at 6-11. We reject the contention that the disallowance was based on a retrospective application of SMDL #02-013 (or any other policy) because the record shows that SMDL #02-013 was not the basis for the disallowance.[12] CMS disallowed the disputed FFP claims as being inconsistent with the state plan, a legally sufficient basis for disallowance.

For the same reason, we decline to decide whether CMS had a consistent policy regarding prison inmate expenditures prior to the issuance of SMDL #02-013. Whether it did or not is irrelevant because New Jersey assented in June 2001 to state plan language that expressly precluded it during the relevant period from classifying expenditures for prison inmate care as DSH payments.

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determination of the prison inmates' Medicaid eligibility. The effect would be to shift costs to the federal government by inflating Medicaid rates for DSH hospitals.

[12] CMS's notice of disallowance does not state that SMDL #02-013 was the basis for the disallowance. NJ Ex. A. The notice merely acknowledges that the OIG had made reference to SMDL #02-013 in its audit findings. Id. at 2. In addition, CMS in its response brief states that it "is not relying on the August 16, 2002 letter as a basis for the disallowance," and that SMDL #02-013 was being "cited as evidence of CMS's consistent policy that Section 1923(g) prohibits a State from making DSH payment adjustments for prison inmate care, as is also expressed in CMS's denial of Rhode Island's State Plan Amendment in 2000, and in CMS's insistence in May 2001, that language prohibiting the claiming of prison inmate costs as DSH payments be inserted in New Jersey's State plan." CMS Br. at 18, n.5.

Conclusion

For the reasons above, we sustain the disallowance of $11,114,820 in FFP.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member